Reaching the Unreached in South Sudan

Community Mobilisers in South Sudan
Their Story and their Network

A network of 2,500 trained community mobilisers, nurtured by UNICEF, helps to reach millions of vulnerable children and their families spread across urban settlements, villages, and remote places. They work within their communities to provide lifesaving information, and to encourage families to avail of health services – including vaccination, maternity care, and education. This story shows how this network began, why it is needed, how it works, and its impact on the well-being of people in South Sudan.
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Reaching the Unreached in South Sudan – the ICMN story – was published in December 2021. It was written and compiled by Diarmuid Peavoy (Communication for Development (C4D), UNICEF Standby Partner, Irish Aid), with contributions from Geeta Sharma (C4D Specialist, UNICEF South Sudan) with Naseem Khan, Iddi Iddrisu and Anson Benjamin Edu (C4D Consultants, UNICEF South Sudan).
Introduction – Making the Impossible Possible

It is a daunting task to conceive, plan and execute a vaccination campaign for a country with an estimated population of 13 million people, a meagre transport infrastructure, limited mass information services and media dark zones, a 40% adult literacy rate, 60 languages, extensive inaccessible areas (due to terrain, conflict, and remoteness) – and an under-developed health system.

Yet in recent years South Sudan has seen several mass vaccinations to counter frequent outbreaks of polio, measles and other VPDs. It is the world’s youngest country, and its poorest in World Bank rankings. It has the lowest human development indicators – including the highest infant and maternal mortality rates. It is larger than either France or Spain and has significant geographical challenges, including regular floods. It also has many security concerns including inter-communal violence and fall-out from the civil wars of 2013 and 2016. Despite its challenges, South Sudan – supported by the international community – has had successful vaccination campaigns in the past five years against polio and measles. It has also had an effective risk-communication campaign against Ebola. Currently a major vaccination effort is under way to fight COVID-19.

Mass vaccination cannot happen unless the population is informed, motivated and mobilised. This presented a huge challenge, given that much of the large population is scattered over South Sudan’s extensive territory, with many logistical, cultural, communicational, political, and administrative difficulties. The key solution to this challenge was the creation of a network of well-trained community mobilisers based in every one of the country’s local government areas, small and large. South Sudan is divided administratively into:

- 10 states and 3 administrative areas
- 79 counties
- 540 payams
- 2,500 bomas (the lowest level of local government)

Each mobiliser is selected from her or his own community and speaks its native language. They report at local level to UNICEF, supported by the Ministry of Health (MoH), in each of the ten states and all three administrative areas; they are thereby linked remotely with headquarters in Juba (the national capital). In this way, life-saving messages can be communicated from Juba to each community in their own language; and communities can be prepared and mobilised for health interventions.

That was the rationale for UNICEF’s proposal in 2017 to create the Integrated Community Mobilisation Network (ICMN) for South Sudan, in collaboration with the National Ministry of Health (NMoH). It took its inspiration from globally recognized models like the Social Mobilisation Network (SMNet) in India, the Volunteer Community Mobilisers (VCM) in Nigeria and similar networks in Afghanistan and Pakistan. However, the ICMN was customised in a context-sensitive manner for the needs of South Sudan.

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1 VDP = Vaccine-Preventable Disease
Why an Integrated Network?

Prior to the creation of the ICMN, there was no structured network that could provide lifesaving messages to the community on regular basis. The ICMN replaced a system whereby community mobilisers were hired only on a short-term basis for work on one-off activities such as a polio vaccination campaign, or other supplemental immunisation activities (SIAs). Under that older system, mobilisers would be hired only for a week at a time. There was no system of regular messaging to communities in need of the health services provided by the Government and its health partners.

Rather than focusing on just one health programme at any one time such as polio vaccination, the ICMN integrates simultaneously all the components of UNICEF’s Mother and Child Survival programme into its regular activities.

It thus fills information gaps in every South Sudan community in relation to Maternal Health, Nutrition, Education, Child Protection, Water, Sanitation and Hygiene (WASH), in addition to Immunisation. Hence the importance of the word ‘integrated’ in its title: Integrated Community Mobilisation Network.

Funding constraints dictate that UNICEF must implement the ICMN project through the state Ministries of health (SMoH), working in partnership with international NGOs.

UNICEF’s Communication for Development (C4D) officers in all 10 states and in all 3 administrative areas, plan, direct, and monitor ICMN activities in collaboration with their communication officers. The C4D officers also oversee ICMN partnerships with NGOs locally i.e., at state level. These NGO partnerships include bodies such CARE South Sudan, which implements the ICMN in nine counties in Unity State; and United Networks for Health (UNH) which covers Upper Nile State and Jonglei State.

The C4D officers are also responsible for the financial management of the ICMN at state level, including the remuneration of community mobilisers. This is done under the guidance of the National MoH and UNICEF’s Country Office in Juba – which also decides on any expansion of the network.

Backbone of South Sudan Operations

In the last five years, the ICMN has had many achievements. What started with three states within the Greater Equatoria region has since expanded to all ten states and all three administrative areas, reaching even the most difficult terrains. This is due in large measure to the collective strength of the ICMN’s networking capacity, and its partnerships with Community Based Organizations (CBOs).

Due to the extraordinary efficacity of this network – with mobilisers fully integrated within every community – follow-up campaigns to combat polio and measles have reached far and wide, achieving over 90% coverage.

©UNICEFSouthSudan/Ongaro An ICMN mobiliser engages with a community member, using a poster as a visual aid.

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2 While the Government of South Sudan had launched its Boma Health Initiative (BHI), it had limited presence as it did not have structures at state level, and administrative area level.
In UNICEF-supported areas of South Sudan, data from the ICMN mobilisers’ field books show that they succeeded in raising immunisation for measles to full coverage, from a low of 47%. Currently, a key aim of the ICMN is to improve routine immunisation (RI) rates.

During the Ebola and COVID-19 outbreaks, the tremendous efforts of the network in all ten states and all three administrative areas, ensured that Risk Communication and Engagement (RCCE) and preventive messages, reached every corner of South Sudan. In the COVID-19 pandemic, the ICMN has played a key role in achieving the administration of over 271,492\(^3\) vaccine doses to date, and a community awareness level of 90%.

This network focused initially on generating demand for polio vaccination, but later it expanded its messaging to promote routine immunisation (RI) – and other health and sanitation interventions – related to maternal and children’s health. It has since become the veritable backbone of UNICEF’s operations in South Sudan.

Through sustained communication, awareness-raising, community engagement, community mobilisation and the use of mass media, UNICEF encourages collective social action to promote:

- Exclusive breastfeeding for children during their first six months
- Balanced feeding of infants and young children – including proper nutrition for pregnant and lactating mothers
- Malaria prevention
- COVID-19 prevention and control
- Vaccination against other communicable diseases such as polio, measles, and Ebola
- Hygiene promotion and the prevention of diarrhoea

The ICMN forms the backbone of these efforts because it reaches deep into the centre of every community, to create awareness of health interventions, and to generate demand for them.

\(^3\) This is the combined figure for all COVID-19 vaccines, as of December 2021.
The ICMN community mobilisers (CMs) are selected from their respective communities for their local knowledge and their communication and language skills – including the language of their own community. Upon recruitment, they are trained over two days in:

- Advocacy and communication skills, to deliver messages effectively, and build trust
- Key health issues, to speak to their communities with authority
- How to increase community awareness and capacity, to ensure good health and hygiene practices
- Tracking the health of mothers and children, through home visits
- Creating links between the local community and healthcare providers
- Building community acceptance and demand for immunisation, and countering resistance to it
- Forming links with community influencers, including religious and lay leaders
- Mobilising communities for mass vaccinations
- Tracking resistant and reluctant families
- Addressing behavioural barriers, through intensive efforts and the support of secondary audiences
- Working collectively to create positive social change, and foster community ownership of it
- How to ensure that the concerns, views, and social behaviours of communities are communicated to UNICEF and the MoH, in a two-way flow of information that strengthens decision-taking

CMs also receive regular refresher training. Careful monthly monitoring ensures no-one is left out.

The ICMN is supported technically by UNICEF and the Ministry of Health (MoH) within the following structure:

1. Community mobilisers (Community Level)
2. Payam supervisors (Payam Level)
3. County supervisors (County Level)
4. UNICEF Communication for Development (C4D) officers – they are the implementation and supervision teams in each of the ten states, with ten EPI Communication Officers to assist them (and 2 more based in NMoH, Juba). These teams plan, monitor and supervise the work of ICMN mobilisers in the various states. They also provide them with technical guidance and on-the-job support.
5. National team, headed by the Director of Health Education and Communication (MoH)

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4 EPI=Expanded Programme on Immunisation
Currently, the ICMN consists of about 2,500 members across all 10 states all 3 administrative areas of South Sudan. UNICEF and the MoH rely on the network for:

- effective advocacy
- behavioural change communication
- social mobilisation

The network provides UNICEF with continuous political, administrative, and social support for immunisation, and generates demand for it. It is a broad-based, community-driven movement, to increase awareness of the people, fieldworkers and partners who deliver health services, and the benefits they all offer.

ICMN mobilisers favour interpersonal communication (IPC) to build trust and reduce resistance to vaccination in their communities. They employ the innovative strategy of building and maintaining supportive linkages with local stakeholders, including chiefs, youth groups, women’s groups, and religious, community, and cultural leaders.

These local networks of influential opinion-leaders help to strengthen the responses to fears and misconceptions in each community. They also reinforce behavioural change messages, and act as a link between the community and the government at a local level.

In addition, data collected by the ICMN is used to understand the types and causes of resistance to immunisation; and to respond to any changes in the humanitarian context. In this way, the ICMN has undoubtedly assisted the evolution of strategies over time to enhance vaccination, build capacity, improve quality, and promote local ownership.

We can say confidently that:

1. Interventions, when informed by ICMN feedback, are responsive to the needs of communities.
2. Wherever the ICMN is active, there is an improvement in the community’s knowledge, awareness, behaviours, and practices in relation to nutrition, WASH, full immunisation coverage and other health interventions.
3. The ICMN is a valuable human resource. It is a well-trained corps owned and accepted by communities. It is also available on tap for child health initiatives, and to reach the unreached with immunisation programs, or broader health initiatives.
4. The ICMN’s focus has widened from polio immunisation to embrace other Mother and Child health services, and immunisation against a range of other diseases, all now integrated in its regular activities.
5. The ICMN and its strategies have proven to be an effective approach to promoting good health practices and strengthening health systems; they can also be replicated successfully elsewhere, especially to enhance universal immunisation programs, and to ensure equitable health delivery, bringing health cover to hard-to-reach areas.
6. The ICMN prefers to engage women as community mobilisers, to incorporate mothers and other caregivers within its ranks. It has empowered women as active policymakers in household decision-taking. This is a fortuitous secondary benefit of the network.

7. The creation of the ICMN has succeeded in reaching the unreached. It has brought health coverage to hard-to-reach areas, and to communities that chronically missed out due to issues of access, or traditional attitudes to healthcare, or heretofore inadequate reach. These areas now receive locally relevant health information, education, and communication (IEC), as well as outreach services.

What a Community Mobiliser Does

Defining Area of Responsibility: A community mobiliser (CM) is responsible for overseeing health messaging and community engagement activities, for 250 to 350 households in her or his vicinity. Mobilisers mark out the boundaries of the area to be covered by their communication activities. They have regular contact with community influencers and religious leaders within that area – be it a boma, town, urban neighbourhood, or rural community.

Household Survey: The first task of all CMs is to visit every household in their area of responsibility to complete a survey. In this survey, they will capture key information for their Field Book, under five thematic headings:

- Polio and routine immunisation
- Hygiene promotion and nutrition
- Early initiation – exclusive breast feeding and complementary feeding
- Education, girls’ education, and child protection
- Birth Notification

The information gathered in the initial household survey will identify eligible families and children for vaccination: 0-5 years for oral polio vaccination (OPV), and 0-1 years for routine immunisation (RI). It will also identify pregnant women and neonatal children for tetanus toxin (TT) and age-specific vaccinations. Information on school-going children will also be included. All details will be entered in the CMs’ Field Books.

Once the survey of targeted households is complete, each mobiliser will prepare a work/movement plan, for visiting those same households each month. Mobilisers also engage frequently with families before, during and between polio rounds, to inform parents about immunisation and its benefits. They address fears and misconceptions, especially in relation to Adverse Events Following Immunisation (AEFI). They also analyse behaviour and identify behavioural barriers to good community health. Their analyses are used to plan further healthcare interventions. After each visit, household information will be updated in the Field Book.

The Field Book: Each CM’s Field Book comprises a series of tables – called ‘tools’ – used to plan and document every aspect of their work, including the information captured during household visits. There are five tools:

- Tool 1 – Monthly work/movement. Planning and activity report.

(Zoom in to view)
• Tool 2 – Household survey

This tool is for gathering information about the families (250 in a rural area and 350 in a town) for which each community mobiliser (CM) is responsible. This is a one-off exercise. Once the target number of houses has been surveyed, the CM will visit them regularly for social mobilisation, health checks, community engagement and updates to basic household data.

If a child misses a routine vaccination, the details will be entered into a defaulter tracking logbook, for follow-up.

Sample (zoom in to view)

<table>
<thead>
<tr>
<th>No.</th>
<th>Name of child</th>
<th>Date of birth</th>
<th>Vaccination status</th>
<th>Reason for default</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>John</td>
<td>01/01/2015</td>
<td>1, 2, 4</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Jane</td>
<td>02/02/2015</td>
<td>1, 3</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>Michael</td>
<td>03/03/2015</td>
<td>2, 4</td>
<td>N/A</td>
</tr>
</tbody>
</table>


**Reason code for not vaccinating the child: 1) Not aware of need for immunization; 2) No one contacted; 3) Concerns for loss of work or wages; 4) Unaware of missed doses; 5) Unfriendly vaccinator; 6) Seen not here; 7) Vaccine was not available; 8) Child away from home; 9) Sick child - caregiver did not opt vaccination; 10) Sick child; 11) Experienced minor illness: fever, pain, swelling; 12) Fear of AEFI; 13) Family is resistant; 14) Health Facility is far away; 15) Others (specify)**

• Tool 3 – Pregnant women identification for institutional delivery, early initiation and exclusive breast feeding

This tool is for the identification of pregnant women, noting the status of institutional delivery (in a health facility), and whether new-born children received colostrum within one hour after birth, and were exclusively breastfed for up to six months. The household number will be given as per household survey tool. The CMs follow up each registered pregnant woman at a health facility, post-delivery.

Sample (zoom in to view)

<table>
<thead>
<tr>
<th>Household number</th>
<th>Pregnant women name</th>
<th>Age at the time of first pregnancy (in Years)</th>
<th>Present Age (in Years)</th>
<th>Status of Institutional delivery</th>
<th>Date of Delivery</th>
<th>Gender of new born (Male/Female)</th>
<th>Has new born received colostrum (first yellow milk) within 1 hour?</th>
<th>Nutrition - Early Initiation, Exclusive Breast Feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Azariah Gabriel</td>
<td>15</td>
<td>17</td>
<td>Yes</td>
<td>20-05-2019</td>
<td>Female</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Gracia Peter</td>
<td>17</td>
<td>18</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Lina Kuku</td>
<td>14</td>
<td>21</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Tool 4 – Community engagement activity – type of meeting, topic, and other details

This tool is to capture all the community engagement activities every month. Kindly use one row for each activity, community mobiliser should fill in the relevant column after every meeting.

Sample (zoom in to view)

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Date</th>
<th>Type of Meeting</th>
<th>Topic of Meeting</th>
<th>Place of Meeting</th>
<th>Total participants</th>
<th>Male</th>
<th>Female</th>
<th>Discussion Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15-10-2019</td>
<td>Community Meeting</td>
<td>Routine Immunization</td>
<td>Chief house</td>
<td>22</td>
<td>12</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>
• **Tool 5** – Information about community influencers.

This tool lists community leaders, influencers, religious leaders, chiefs, and other influencers who support social mobilisation activities in the CM’s area.

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Name of Influencers</th>
<th>Religion</th>
<th>Designation/Position</th>
<th>Type of support provided by influencers</th>
<th>Contact No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Daniel Majak Manyang</td>
<td>Christian</td>
<td>Pastor</td>
<td>Announcement from Church and mobilization support</td>
<td>002xxxxxxx</td>
</tr>
<tr>
<td>2.</td>
<td>Ibrahim Sehata</td>
<td>Muslim</td>
<td>Chief Sheikh</td>
<td>Announcement from Mosque and mobilization support</td>
<td>091xxxxxxx</td>
</tr>
</tbody>
</table>

• **Summary Report – Form C (and its sub-Forms)**

Every mobiliser is obliged to complete Form C, every month. This comprises one updated household report and 8 distinct sub-reports summarising the activities and figures of the month. The sub-reports cover:

- Diarrhoea/cholera
- Education – numbers in school, reasons for not going to school
- Routine Immunisations – including reasons for non-vaccination
- Deliveries by pregnant women – including the reason for every birth at home (rather than at a health facility)
- Community Engagement Meetings – EPI-Polio, Nutrition, Education, Hygiene, Birth Registration, COVID-19 etc., stating where they were held and with which groups
- Details of meetings with influencers – where, who, gender, designation, number of participants etc.
- Megaphone announcements\(^5\) - including where delivered and the purpose; and an estimation of the numbers reached
- Polio and COVID-19 vaccinations – how many given, how many missed etc.
- Any other information relevant information

• **Collation of Summary Reports – at Payam, County, State and National Levels**

The mobilisers’ monthly reports (Form C and its sub-forms) are collated first at payam level. The aggregated numbers and details at payam level, are then collated at county level. The county summaries are then collated at state level, for all 10 states and all 3 administrative areas. These are finally collated at national level.

This national monthly information is visualised in dashboard format (see the sample image on Page 12 below) to clearly show the status of key health indicators, primarily for mothers and children. This is shared with all stakeholders at national and state level.

It is important to realise that this valuable monthly information comes from grassroots communities throughout the country. In this way, reliable information is passed regularly from community mobilisers and their households at grassroots level, to those responsible for designing key health interventions for the entire population of South Sudan.

Thus, the voices of communities at local level can inform the design and implementation of health policies and interventions at national level. Thus, they contribute ideas nationally, to benefit locally.

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\(^5\) Mobilisers are given megaphones to deliver key messages in public places to their designated communities, and to mobilise their communities for vaccinations and other interventions. They are also provided with communication materials – including pictorial flip charts – to conduct interpersonal communication (IPC) and other community engagement activities, at the grassroots level. The CM holding a megaphone is now an iconic image of UNICEF in South Sudan.
ICMN Dashboard

Contribution to National Health Data

The extensive and varied data collected by the ICMN mobilisers is captured every month in a PowerPoint slide presentation, known as the Dashboard. This provides a snapshot of the social mobilisation activities in the ten states and three administrative areas.

It shows and includes:

- The number of community mobilisers (CMs)
- What is being done well – what health interventions are working and what needs to be changed
- The numbers of children in target age groups
- The numbers of children not attending school and the reasons why
- Interpersonal communication work carried out in households and elsewhere
- Meetings held in schools and churches
- Details of announcements in mosques and public places
- Routine immunisation (RI) data, including children's vaccinations missed and why
- Home births – and the reasons why they did not take place at health facilities
- Details of trainings conducted.

The dashboard is an invaluable resource for advocacy and health promotion. Its data is also used to drive the planning of communications.

It is hoped that the Dashboard will soon be available online, and integrated into the Government of South Sudan’s online reporting system for health activities, known as the District Health Information System 2 (DHIS 2). Read more below under Key Challenge.

When the information gathered by the ICMN can be integrated into DHIS 2, it will become an integral part of the country’s historical health data. This will support evidence-based planning and decision-making, as well as the implementation and monitoring of health activities.

It will also guide and strengthen advocacy, to generate demand for vaccination and other health services.

Health Data by County

The ICMN data is entered into the Power BI software programme, which visualises analytical data. It is used to produce a health profile for each county, state, and administrative area.

This enables the generation of a PowerPoint presentation for each county, state, and administrative area, covered by the ICMN.

The presentations show the key performance indicators of the risk communication and community engagement (RCCE) activities. These indicators are evaluated regularly, allowing for strategic changes and improvements, as needed.

Creating Social Maps

The data amassed by the ICMN mobilisers has also enabled members of UNICEF’s Communications for Development (C4D) team to develop Social Maps for each county. Once printed, these Social Maps are distributed to partners, as they contain social data that guide internal and external partners in planning humanitarian activities, wherever a humanitarian response is needed.

Key data contained in the ICMN field books include population, areas of settlement in different seasons, numbers of households and villages, accessibility mapping – and reasons for the inaccessibility of some locations – as well as other data.

The Social Maps, based on ICMN field book data, are updated every year. However, lack of funding sometimes affects timely updating of the Social Maps, due to the time and manpower needed to collect data.

Key Challenge

There is a significant lacuna in health reporting through the Government health data system, known as the DHIS 2 (District Health Information System 2). This lacuna is a major challenge.

Under current arrangements, valuable ICMN data is collected and given to each county health
department and all state Expanded Programme on Immunisation (EPI) teams, for the purpose of being entered in – and captured by – the DHIS 2.

This data is then shared directly with the national Ministry of Health (MoH) through its Health Promotion and Education Department.

Unfortunately, however, the ICMN data is not shared with the MoH through the Government’s own DHIS 2 system. This allows the data to be lost, or left sitting somewhere off the reporting system. It is consequently excluded from South Sudan’s historical health data base.

Given this challenge, we recommend the following:

- Connect the existing ICMN dashboard to DHIS 2, by transferring historical data to it.
- Develop/revise clear health promotion indicators for community mobilisation.
- Review all data collection/reporting tools, for routine community mobilisation data.
- Support the NMoH’s Health Promotion and Education Department, through supportive supervision, to enable evidence-generation and advocacy, at the highest levels of Government.

Sample Dashboard Slide

This is a sample from the Dashboard’s thirteen PowerPoint slides. Each slide visually summarises an aspect of the data collected over a month.

(Zoom in to view)
Meet a Community Mobiliser

My name is Victoria Hayat. I am 26 years old.

I work as a community mobiliser in Yambio, Western Equatoria State, South Sudan.

This has been my job for the last three and a half years. It is also my first job.

My work is to educate people in my community on good behavioural practices in health, nutrition, education, hygiene, and child protection. Typically, I talk to people about the importance of sending children to school, and the importance of washing their hands before eating and after using the toilet.

In a day, I visit 13 households reaching about 78 people with lifesaving messages.

Before leaving my house every morning, I make sure that I have all the communication material and teaching aids I need to perform my job well. These include my megaphone, posters, banners, and charts, not forgetting my apron – which helps in identifying myself to the community.

I like my job because I get to interact with the community. They like me because I am giving them important information. However, sometimes people do not allow me into their homes which makes my job challenging, as we know that direct conversation is what works best for changing people’s behaviour.

When I visit families, I look at immunisation records of children and advise mothers when to take their children to the health facility again. I also promote breastfeeding, hygiene, and education – especially for girls, because of their high drop-out rate from school in my village.

I also make announcements in churches, streets, and markets. By doing this, I can reach those who are not in their homes, with lifesaving messages.

I also make announcements in churches, streets, and markets. By doing this, I can reach those who are not in their homes, with lifesaving messages.

Some of the community mobilisers I work with create awareness on positive behaviours in schools. We focus there on handwashing, as it is essential to prevent several diseases. We are not only saying it, we are also showing it.

Community mobilisers also carry out health education at health facilities. By working in homes, markets, schools, and streets, we reach many people within a short time frame. That can be particularly important when dispelling rumours in the community. As you know, rumours spread faster than good information.

The job of a community mobiliser is not easy because we walk for long distances every day, but every kilometre we walk is worth it, because we are helping our communities.

Today we are faced with a new fear – the fear of coronavirus disease. The communities are always asking questions. It is our role to educate them on the signs and symptoms of the disease, and how to prevent it. UNICEF has given us training and we are sharing what we now know with our communities, so they know how to stay safe.
Integrated Community Mobilisation Network (ICMN) – Reaching the Unreached in South Sudan

Mobilisers Making a Difference

Action by ICMN mobilisers dramatically increases vaccinations

Tonj Hospital Vaccination Centre, Warrap State, 11 June 2021. The first days of the vaccination saw long queues with many people lining up to receive a jab of the COVID-19 AstraZeneca vaccine.

However, as time went by, the numbers of people coming for vaccines began to diminish. On the second, third and fourth days, the numbers dropped to 20 people per day, well below the projected 80 per day. A rapid assessment indicated an information gap in the community concerning the COVID-19 vaccine – some health workers even had reservations about it themselves – because of misinformation and disinformation linked to the new vaccine.

The Integrated Community Mobilization Network (ICMN) then got to work. They used a variety of communication activities, so that by Day 6 they had increased the daily COVID-19 vaccinations at the hospital from 20 to over 200 people per day.

The ICMN team’s activities included community meetings with religious and community leaders, teachers, youth, and women’s groups, to identify concerns. They then brought in the County Health Department and clinical experts, to answer questions and counter vaccine hesitancy.

One community mobiliser, 35-year-old John Malith, used his role as a priest to reach out and engage communities around in Tonj on the importance of receiving a COVID-19 vaccine. He got vaccinated himself and carried his vaccination certificate while mobilising others.

It is the evening before the launch of National Immunisation Days (NIDs) in Luonuyaker, Bahr el Ghazal State. The 32-year-old polio victim and community mobiliser, James Giir, hand-wheels himself through town using only one arm. He is dressed in the ICMN’s iconic blue poncho and cap.

With the other arm he is holding his megaphone to announce in a firm voice: “The polio campaign starts tomorrow. All children under five should be taken for vaccination.”

During this campaign, James starts work at seven in the morning and often finishes as late as nine in the evening, as he knows he needs to be active when people are home and ready to listen.

“Look at me,” he says, “if this vaccine was available when I was a child, I wouldn’t have lost my legs.”

Being paralysed by polio could have destroyed his life but instead, the father of two uses it to inspire his life’s biggest mission and is making a difference in thousands of children’s lives.

His determination is clear: “I don’t want any other child to suffer like me, when vaccines are here to save their lives.”
Community mobiliser motivated by his childhood experience

Nyok Daniel manages a team of community mobilisers in Malakal, the capital of Upper Nile State. Since childhood he has been battling preventive diseases and caring for others. From the age of twelve he babysat five siblings and looked after household chores for his widowed mother, while they trekked from town to town in search of better basic services. He was too busy, he says, to attend school.

Now aged 26, Nyok says his mission is to ensure mothers are protected from preventable diseases, and their children are freed from household chores in order to attend school, to avoid them having to repeat his own childhood experience. When schools were closed for a period due to the COVID-19 pandemic, Nyok encouraged children to listen to distance-learning programmes, supported by UNICEF on radio, or on mobile phones.

On his round one day, Nyok encounters 16-year-old Mathok Awen sitting with a borrowed mobile phone to his ear, listening to a distance-education broadcast. Nyok sits with Mathok for a while, and holds the phone for him while the youth scribbles answers to questions into his notepad. “I take my notes”, says Mathok, “I also have a timetable. I read and follow the programme”.

Nyok applauds Mathok’s dedication, but he is concerned that children are now becoming more involved in business, to support themselves during the pandemic, to the detriment of their education.

Nyok moves on to conduct a meeting with religious leaders, and to make public announcements through his megaphone in the busy city streets. Wearing his UNICEF poncho, he faces a group of women arranging food on roadside stalls and announces through his megaphone: Avoid close contacts and handshakes – wash your hands frequently with soap and water – protect yourselves from the coronavirus. Later, facing a group of men drinking tea in a makeshift restaurant, he uses his megaphone to warn them: Maintain physical distance from each other!

Nyok has successfully organised his community mobilisers (CMs) to counter pervasive negative rumours against the COVID-19 vaccinations, and says “we had to move to all the schools, and from house to house, to give the right information”. They also held public meetings and displayed posters to debunk rumours, raise awareness and advocate for vaccination.

Before attending one such meeting, Ms Bushai Ayat Othou – who lives with her children in a camp of 25,000 displaced people – had heard about the vaccine from the CMs, but became discouraged by rumours and myths. “I even stopped my children from going to school,” she says, “after they and other children ran out of class one day, on hearing unfounded rumours about the vaccine.”

However, Bushai was eventually persuaded by what she heard at the meeting, adding “we also saw people there who had taken the vaccine, so we took it seriously”. Pictured here with her COVID-19 certificate, she got the jab herself three weeks later, at a humanitarian centre in the camp, and said “I slept well afterwards and didn’t feel any effects.”

Bushai now advocates for the vaccine within her camp community, assuring people it is safe and effective. She also thanks Nyok and the CMs for teaching her further protective measures – regular hand washing, mask wearing, social distancing, avoiding handshakes and unnecessary travel.
James Mabior Mading, is a sub-chief in the village of Baiporo, Yambio County, Western Equatoria State. In addition to his duties as a sub-chief, he was trained by UNICEF as a community mobiliser (CM), four years ago.

Mabior’s village is only 40km away from the Democratic Republic of Congo (DRC). He lived there for a while, to escape war in his homeplace. So it is no surprise that he spoke out strongly in his dual role, about the need for positive health behaviour, after outbreaks of Ebola in DRC in recent years. He has also been working with UNICEF and other partners to select and mentor the CMs who are calling to homes and holding public meetings, to spread their lifesaving messages.

Sixty-eight year old Mabior is aware of how much his village respects him, and listens to his advice. He has been able, he says, to stop his community from going to war. Today, he plays an essential role when it comes to dispelling rumours and correcting misinformation concerning Ebola and other diseases. He says: “We have been living in fear of Ebola, because there have been cases very close to us in the Congo. But some people were misinforming the community, saying that if you live deep within the forest you will not contract Ebola, so I have to correct such misinformation.”

On foot of his urgent advocacy concerning Ebola, James Mabior Mading watched with concern the dark clouds of COVID-19 gathering. So he promptly decided to learn as much as he can about “this dangerous new disease”, to inform his community.

Forty-year old Momo Manasseh, spent 17 years in a refugee camp in Uganda, having fled there with his family, as a six-year-old boy. He well remembers how his family were forced to walk for three days from their home village of Sarego, in southern South Sudan, to reach Uganda. He has now returned as a University-educated professional to contribute to his country as a relief worker.

As Head of Programmes for The Rescue Initiative – South Sudan (TRI-SS), Momo works with UNICEF to train community mobilisers, and to inform local communities about measures to prevent infection. TRI-SS is a non-governmental organisation (NGO). It is one of UNICEF’s partner organisations in South Sudan, for implementing risk communication and community engagement (RCCE) activities.

Working with UNICEF on the COVID-19 response, Momo and TRI-SS have trained over 350 community mobilisers. “With the support of UNICEF”, he says, “we also inform local communities about good practices in health, including vaccination.”

“We trigger a demand from the local population to get the services they need in health, education, child protection and other areas. Any programme being implemented by a Government or aid organisation can only be successful, and sustainable, if people are asking for it themselves.”
Afterword

Network for South Sudan’s Unique Context

Access to information is an enormous challenge in South Sudan. Insecurity, displacement, high illiteracy rates, poverty, nomadic pastoral lifestyles, gender inequities and the fact that 83 per cent of the population lives in rural areas where connectivity is extremely poor – all contribute to the informational challenge. It is also a challenge to reach high risk settings such as crowded and congested neighbourhoods, with life-saving messages on COVID-19.

The Integrated Community Mobilisation Network (ICMN) is one of the actions that the Government of South Sudan, UNICEF, and their partners, designed specifically to address South Sudan’s unique context and challenges. It allows UNICEF and its partners to strengthen community engagement and build community trust and ownership, while promoting and bringing about, positive behavioural change.

The ICMN ensures the communities we are working with are informed and involved in the work we do. Communities help us to select mobilisers who become their champions of change. Through this network, we work with over 2,500 women and men in all 10 states and all 3 administrative areas, in carrying out effective two-way communications aimed at increasing awareness of COVID-19, and measures to prevent infections.

These prevention and response efforts allow UNICEF to engage with some of the most vulnerable and marginalized populations, including those who are displaced, and people with disabilities. Our approach also ensures inclusion – working with rural and urban populations, and various ethnic groups including pastoralists. We use a face-to-face approach to communications, with an emphasis on house-to-house visits. This allows UNICEF and its partners to reach women and girls who might otherwise have missed out on lifesaving information, due to traditional gender roles, and social norms that make them the primary care givers for children, the sick and the elderly.

Since we started risk communication and community engagement (RCCE) activities in South Sudan in March 2019, we have trained more than 2,500 social mobilisers in COVID-19 messages, which they are relaying to communities through interpersonal communication and megaphone announcements; we have also printed and distributed close to 500,000 banners, posters and leaflets in five different languages; we engaged with more than 40 radio stations who aired radio talk shows and information jingles in 10 different languages. Together with our partners we have reached 3.4 million people in South Sudan.

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